On Call Staffing

Please Print Clearly

Client Name: _____

Employee Name: _____

Classification: ____RN _____LPN _____CNA _____Other

Date Worked: _____ Unit/Floor_____

Shift:_____ Time In: _____ Time Out:_____

Total Hours: _____

Meal: (30 Min) Yes No Over Time Approved Yes No (approved by facility)

I recognize the rights of On Call Staffing as the employer and agree not to employ directly in any capacity the person named hereon without first providing On Call Staffing at least ninety (90) days notice following the termination of this assignment. I certify that the hours shown above are correct and the employee performed satisfactory.

_____

Signature of Authorized Client Only

I certify that the hours shown above represent my total hours worked and that they were properly verified by the client or by an authorized representative. I also certify that I was not injured on the above shift.

_____

Employee Signature

Pay slip must be returned to On Call Staffing within seven (7) days.

Original to On Call Staffing. Copies to Client and Employee.